Sample Form: Discussion and Consent for Treatment

Patient's Name:_____ Date of Birth:_____
Last *First* *Initial*

I am being provided with this information and consent form so that I may better understand the treatment recommended for me. Before making a treatment decision, I wish to be provided with enough information, in a way I can understand, in order to make a well-informed decision regarding my proposed treatment.

I understand that I may ask any questions I wish, and that it is better to ask questions prior to treatment than to wonder about it after treatment has started.

Nature of the Recommended Treatment

It has been recommended that I have the following treatment:_____

_____

_____

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been taken into consideration. The treatment is necessary because of:

☐ Pain ☐ Infection ☐ Periodontal (gum) disease ☐ Decay ☐ Broken Tooth/Teeth
☐ Other_____

The intended benefit of this treatment is:_____

_____

The prognosis, or likelihood of success, of this treatment is:_____

My treatment is estimated to take _____ visits to complete, but I understand it could be shorter or longer based on what happens when treatment begins.

My treatment is estimated to cost $_____. I understand this is only an estimate and that I will be informed as soon as possible if the cost estimate changes.

Alternative Treatments

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative methods to treat my dental condition include:_____

_____

No other reasonable treatment option exists for my condition.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including:_____.
Patient's Initials

Risks of the Recommended Treatment

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment.

I understand that I may be given a topical anesthetic and/or local anesthetic injection. Although rare, it is possible that patients may have an allergic reaction to these medications. Adverse reactions to anesthetic medications are possible, such as lightheadedness, dizziness or drowsiness. Please contact Dr. _____ if numbness remains more than a few hours or if you develop a rash.

continued…

I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that some after-treatment effects and complications tend to occur with regularity. These include:_____

_____

_____

I understand that undergoing dental care and treatment may increase the risk of respiratory virus or other infections, due to close proximity with dental healthcare personnel and others from the community.

I understand that healthcare personnel or others from the community may be carriers of a respiratory virus or other infections and may not show disease symptoms, even if infected. Therefore, I understand that I may be exposed to disease-causing germs and become infected with a communicable disease.

I understand that my dental procedure, or procedures performed on other patients before or during my dental visit, may result in the creation of an aerosol (droplets in the air). The presence of aerosol may increase the risk of infection as a result of breathing in droplets that contain disease-causing germs. One example of this exposure is coronavirus and COVID-19 infection.

I also understand that the office of Dr. _____ complies with current infection prevention and control guidelines and that all appropriate steps are being taken to lower the risk of transmission and infection by disease-causing viruses or bacteria during my dental visit. This protocol includes work practice controls, procedures and protective equipment to help prevent infections that may be passed on through close contact, respiration (breathing), or exposure to infected blood or saliva.

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about.
Patient's Initials

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including medications I am currently taking (antibiotics, pain drugs, or other medications, including non-prescription medicines, herbs or supplements) and materials or medicines to which I am allergic. I will follow any and all treatment and post-treatment instructions as directed and explained to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warrantees, or representations have been made to me concerning the results of the procedure.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.

I wish to proceed with the recommended treatment.

Specialty Treatment Acknowledgement (if applicable)

_____ I understand that this procedure can also be performed by a _____
Patient's Initials
(a dental specialist). I understand the risks associated with this treatment and elect to have this procedure performed by Dr. _____.

_____ I understand that if any unexpected difficulties occur during treatment, I may be referred to a _____
Patient's Initials
(a dental specialist) for further care.

Signed:_____ Date:_____
Patient or Guardian

Signed:_____ Date:_____
Treating Dentist

Signed:_____ Date:_____
Witness